THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION:

SOAH DOCKET NO. 453-04-4231.M5

MDR Tracking Number: M5-04-1115-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on December 18, 2003.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the ultrasound, massage, iontophoresis, electrode, paraffin bath, myofascial release, and office visits were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatments listed above were not found to be medically necessary, reimbursement for dates of service from 01-02-03 to 01-23-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 20th day of February 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

MEDICAL REVIEW OF TEXAS

3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:
MDR Tracking Number: M5-04-1115-01
Name of Patient:
Name of URA/Payer:
Name of Provider: (ER, Hospital, or Other Facility)
Name of Physician: (Treating or Requesting)

February 13, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating

physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Rosalinda Lopez, Texas Workers Compensation Commission

RE:

CLINICAL HISTORY
Approximately 300 pages of medical records were reviewed. 53-year-old right handed female with left shoulder injuries, the last of which was on ___. She has a history of arthroscopy and rotator cuff repairs as well as long-term physical therapy and conservative treatment. Also, she has noted left glano-humeral joint multi-directional instability. More recently lateral opi candxlitis h as been added to her list of problems.

REQUESTED SERVICE(S)
Ultrasound, massage, iontophoresis, electrode, paraffin bath, myofascial release, office visits for 1/02/03 through 1/14/03 and 1/16/03 through 1/23/03.

DECISION
Denied.

RATIONALE/BASIS FOR DECISION
According to peer-reviewed literature by Dr. R.E. Winsor, et al, in 1993, treatment guidelines outlined by Jeffrey L. Young, MD in the *Low Back Pain Handbook*, 1997, the Quebec task Force, and Drs. D. Weber and R. Brown in Braddom's text :*Physical Medicine and Rehabilitation*, therapeutic modalities are best used during the acute phase of rehabilitation. These are considered adjunctive treatments rather than primarily curative interventions. There is no peer-reviewed randomized-controlled literature to support myofascial release.